Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RICHARDO C SCHACK MD
PO BOX 202212
DALLAS TX 75320

Respondent Name

POLY AMERICA LP

Carrier's Austin Representative Box

Box Number 11

MFDR Tracking Number

M4-10-3636-01

MFDR Date Received

APRIL 15, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not in network/Per MAR."

Amount in Dispute: $1,003.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated April 26, 2010: "With regards to date of service 12/1/09, the Carrier first received the bill on 3/16/10 and payment was issued on 4/8/10 with the same network reduction taken as the other bills."

Response Submitted by: Avizent

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2009 May 28, 2009 June 30, 2009 September 1, 2009 September 15, 2009 November 3, 2009 December 1, 2009 December 29, 2009	CPT Code 99243 Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	$729.92	$619.91
July 28, 2009 October 6, 2009	CPT Code 99244 Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the	$273.60	$273.60

	patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.		
TOTAL		$1,003.52	$893.51

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
3. 28 Texas Administrative Code §133.4 effective July 27, 2008 sets the guidelines for notification on contractual agreements.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45-Charges exceed your contracted legislated fee arrangement.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Is the requestor entitled to reimbursement for CPT code 99243 and 99244?

Findings

1. The insurance carrier reduced disputed services with reason code "45". Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 29, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2009 DWC conversion factor for this service is 53.68.

   The Medicare Conversion Factor is 36.0666

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75050, which is located in Grand Prarie, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Dallas.

Using the above formula, the Division finds the following:

Code	Calculation for Locality Dallas	Maximum Allowable Reimbursement	Respondent Paid	Due
99243	(53.68/36.0666) x $125.97 for 8 Units	$1499.91	$880.00	$619.91
95903	(53.68/36.0666) x $185.98 for 2 Units	$553.60	$280.00	$273.60
TOTAL		$2,053.51	$1,160.00	$893.51

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due for the specified services. As a result, the amount ordered is $893.51.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $893.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/01/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.